		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044313

Facility Name: Cardinal Health Care

Address: 210 East College (Number) Energy (City) 62933 (Zip Code)

County: Williamson

Telephone Number: (618) 942-7014 **Fax #** (618) 942-7196

IDPA ID Number: 37-1377445002

Date of Initial License for Current Owners: 06/09/1999

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 04/30/2001 (Date)
(Type or Print Name) Ronald A. Hunter
(Title) President

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,476	3
4	73	Intermediate/DD	73	26,718	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,194	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	23,121	3,012	569	26,702	10
11	ICF/DD	12,890			12,890	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,011	3,012	569	39,592	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.03%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 09/30/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	166,856	24,699		191,555		191,555		191,555			1
2	Food Purchase		136,353		136,353		136,353	(12)	136,341			2
3	Housekeeping	99,683	15,245		114,928		114,928		114,928			3
4	Laundry	58,769	5,632		64,401		64,401		64,401			4
5	Heat and Other Utilities			76,045	76,045		76,045		76,045			5
6	Maintenance	80,533	33,796	74,208	188,537		188,537		188,537			6
7	Other (specify):*											7
8	**TOTAL General Services**	405,841	215,725	150,253	771,819		771,819	(12)	771,807			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,386,675	68,080	28,129	1,482,884		1,482,884		1,482,884			10
10a	Therapy			3,985	3,985		3,985		3,985			10a
11	Activities	47,044	1,686		48,730		48,730		48,730			11
12	Social Services	38,305		7,275	45,580		45,580		45,580			12
13	Nurse Aide Training	20,364	425		20,789		20,789		20,789			13
14	Program Transportation			782	782		782		782			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,492,388	70,191	49,771	1,612,350		1,612,350		1,612,350			16
	C. General Administration											
17	Administrative	135,100			135,100		135,100		135,100			17
18	Directors Fees											18
19	Professional Services			70,586	70,586		70,586		70,586			19
20	Dues, Fees, Subscriptions & Promotions			11,736	11,736		11,736	(225)	11,511			20
21	Clerical & General Office Expenses	70,251	23,286	69,955	163,492		163,492		163,492			21
22	Employee Benefits & Payroll Taxes			370,447	370,447		370,447		370,447			22
23	Inservice Training & Education			960	960		960		960			23
24	Travel and Seminar			820	820		820		820			24
25	Other Admin. Staff Transportation			773	773		773		773			25
26	Insurance-Prop.Liab.Malpractice			18,626	18,626		18,626		18,626			26
27	Other (specify):*											27
28	**TOTAL General Administration**	205,351	23,286	543,903	772,540		772,540	(225)	772,315			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,103,580	309,202	743,927	3,156,709		3,156,709	(237)	3,156,472			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Cardinal Health Care #0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			28,748	28,748		28,748		28,748			30
31	Amortization of Pre-Op. & Org.			200	200		200		200			31
32	Interest			36,805	36,805		36,805		36,805			32
33	Real Estate Taxes			57,500	57,500		57,500		57,500			33
34	Rent-Facility & Grounds			195,000	195,000		195,000		195,000			34
35	Rent-Equipment & Vehicles			56,445	56,445		56,445	(19,107)	37,338			35
36	Other (specify):*											36
37	**TOTAL Ownership**			374,698	374,698		374,698	(19,107)	355,591			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,107		22,107		22,107		22,107			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,291	87,291		87,291		87,291			42
43	Other (specify):* Nonallowable costs			23,042	23,042		23,042	(23,042)				43
44	**TOTAL Special Cost Centers**		22,107	110,333	132,440		132,440	(23,042)	109,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,103,580	331,309	1,228,958	3,663,847		3,663,847	(42,386)	3,621,461			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,152)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(19,107)	35		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(71)	43		18
19	Entertainment				19
20	Contributions	(150)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(657)	43		24
25	Fund Raising, Advertising and Promotional	(3,474)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,775)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,386)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	-		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (42,386)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Cardinal Health Care

ID# 0044313

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ronald A. Hunter	100.00%	Cardinal Hill Health Care	Greenville, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Ronald A. Hunter	President	Administrative	100.00%	12,500	40+	60.00	Salary	$ 58,679	17-1	1
2	Benjamin Hunter	Maintenance	Maintenance	0.00%	7,840	40	100.00	Salary	19,040	6-1	2
3	Veronica Hunter	VP of Operations	Administrative	0.00%	0	40	100.00	Salary	36,623	17-1	3
4	Edgar Hunter	Maintenance	Maintenance	0.00%	7,520	20	50.00	Contract Labor	9,420	6-1	6
5											5
6											6
7											7
8	* Ronald, Benjamin & Edgar Hunter received "Other Compensation" from Cardinal Hill Health Care in Greenville, Illinois										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 123,762		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4				N/A						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Financial Pacific Leasing		X	Lease obligation	567.00	04/01/99	$ 13,719	$ 10,404	04/01/03	0.3882	$ 5,819	1
2	Telmark		X	Lease obligation	309.00	08/01/99	10,650	8,266	05/01/03	0.1931	2,370	2
3	Vorton Financial		X	Lease obligation	285.00	01/02/00	10,317	7,210	11/01/03	0.1450	2,116	3
4												4
5												5
	Working Capital											
6	American National Bank		X	Working capital	None	06/28/99	190,000	190,000	06/28/01	0.1000	19,000	6
7	American National Bank		X	Working capital	5,000.00	06/28/99	75,000	75,000	06/28/01	0.1000	7,500	7
8												8
9	TOTAL Facility Related				6,161.00		$ 299,686	$ 290,880			$ 36,805	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 299,686	$ 290,880			$ 36,805	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 14,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 9,800	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,900)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 62,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 57,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	49,673	8
	1996	52,913	9
	1997	53,435	10
	1998	57,130	11
	1999	57,535	12

2000 accrual = prior year real estate tax bill rounded to nearest $100.=		57,500	
1999 over accrual		4,900	
Total		62,400	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,850 B. General Construction Type: Exterior Brick Veneer Frame Masonry Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 1,000
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 200
4. Dates Incurred: 1999

Nature of Costs: Incorporation fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159			1972	$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof repairs			1999	5,250	350	15	350		525	9
10	A-Wing renovations			1999	7,008	467	15	467		701	10
11	C-Wing kitchen - electrical supplies			1999	510	34	15	34		51	11
12	Laundry building renovations			1999	31,280	2,085	15	2,085		3,128	12
13	Landscaping - garden area			1999	5,225	348	15	348		522	13
14	A-Wing renovations			1999	144,174	9,412	15	9,412		14,418	14
15	C-Wing renovations			1999	61,734	4,116	15	4,116		6,174	15
16	Architectural services for A-Wing & C-Wing renovations			1999	4,610	307	15	307		461	16
17	Security system for A-Wing, B-Wing, C-Wing			1999	31,221	2,081	15	2,081		3,122	17
18											18
19	A-Wing renovations completed			2000	10,261	342	15	342		342	19
20	C-Wing renovations completed			2000	42,155	1,405	15	1,405		1,405	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 343,428	$ 20,948		$ 20,948	$	$ 30,849	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 46,406	$ 4,641	4,641	$	10	$ 6,961	37
38	Current Year Purchases	19,797	990	990		10	990	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 66,203	$ 5,631	$ 5,631	$		$ 7,951	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident care	Van	1999	$ 10,843	$ 2,169	$ 2,169	$	5	$ 3,253	42
43										43
44										44
45										45
46	TOTALS			$ 10,843	$ 2,169	$ 2,169	$		$ 3,253	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 420,474	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 28,748	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 28,748	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 42,053	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53		N/A			53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59		N/A	59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: American National Bank & Trust of Chicago Trustee for Trust No. 12115-07

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	159	10/01/98	$ 195,000	20	None	3
4	Additions							4
5								5
6								6
7	TOTAL		159		$ 195,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. None
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [X] YES [ ] NO Terms: See attachment *

10. Effective dates of current rental agreement:
Beginning 10/01/1998
Ending 09/30/2018

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 195,000
13.	12/31/2002	$ 255,000
14.	12/31/2003	$ 255,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 32,418 Description: Copiers - 11,657; security system - 8,030; oxygen concentrators - 2,302; telephone - 10,429
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Maintenance	91 Ford pickup	$ 410	$ 4,920	17
18	Administrative	97 Neon(2)	823	9,876	18
19	Resident care	Van	769	9,231	19
20	Less Non-Allowable Lease Expense			(19,107)	20
21	TOTAL		$ 2,002	$ 4,920	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			425		425
3	Classroom Wages	(a)		10,148		10,148
4	Clinical Wages	(b)		4,510		4,510
5	In-House Trainer Wages	(c)		5,706		5,706
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 20,789	$	$ 20,789
10	SUM OF line 9, col. 1 and 2	(e)	$ 20,789			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 1,012

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	17
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	17

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	144	$ 1,260	$	144	$ 1,260	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		436	2,725		436	2,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				19,850		19,850	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39(2)					2,257		2,257	13
14	TOTAL			$	580	$ 3,985	$ 22,107	580	$ 26,092	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 21,402	$ 21,402	1
2	Cash-Patient Deposits	3,146	3,146	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	420,388	420,388	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,905	44,905	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,920	4,920	8
9	Other(specify): See attached	140,917	140,917	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 635,678	$ 635,678	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	343,428	343,428	15
16	Equipment, at Historical Cost	77,046	77,046	16
17	Accumulated Depreciation (book methods)	(42,053)	(42,053)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,000	1,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(433)	(433)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 378,988	$ 378,988	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,014,666	$ 1,014,666	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 275,944	$ 275,944	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,146	3,146	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,738	47,738	30
31	Accrued Taxes Payable (excluding real estate taxes)	629,079	629,079	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,400	62,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other current liabilities (see attached)	334,443	334,443	36
37	Short-term obligations	25,880	25,880	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,378,630	$ 1,378,630	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	265,000	265,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 265,000	$ 265,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,643,630	$ 1,643,630	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (628,964)	$ (628,964)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,014,666	$ 1,014,666	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (183,309)	1
2	Restatements (describe):		2
3			3
4	**Prior year adjustments subsequent to cost report preparation**	51,016	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (132,293)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(496,671)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (496,671)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (628,964)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,157,345	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,157,345	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,012	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,012	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous income	8,807	28
28a	Meal income	12	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,819	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,167,176	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	771,819	31
32	Health Care	1,612,350	32
33	General Administration	772,540	33
	B. Capital Expense		
34	Ownership	374,698	34
	C. Ancillary Expense		
35	Special Cost Centers	45,149	35
36	Provider Participation Fee	87,291	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,663,847	40
41	**Income before Income Taxes (line 30 minus line 40)****	(496,671)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (496,671)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
Tax year & reporting year differ.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,645	1,758	$ 30,679	$ 17.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,432	9,707	118,680	12.23	3
4	Licensed Practical Nurses	26,064	26,804	282,752	10.55	4
5	Nurse Aides & Orderlies	50,018	51,604	367,234	7.12	5
6	Nurse Aide Trainees	2,600	2,600	20,364	7.83	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,992	2,090	19,641	9.40	8
9	Activity Director	520	520	5,206	10.01	9
10	Activity Assistants	6,636	6,788	41,838	6.16	10
11	Social Service Workers	3,641	3,835	38,305	9.99	11
12	Dietician					12
13	Food Service Supervisor	2,067	2,086	17,387	8.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,623	23,491	149,469	6.36	15
16	Dishwashers					16
17	Maintenance Workers	6,564	6,685	80,533	12.05	17
18	Housekeepers	17,522	17,818	99,683	5.59	18
19	Laundry	9,869	10,196	58,769	5.76	19
20	Administrator	2,021	2,086	39,798	19.08	20
21	Assistant Administrator					21
22	Other Administrative	2,868	2,932	95,302	32.50	22
23	Office Manager					23
24	Clerical	7,569	7,856	70,251	8.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13,020	13,976	132,955	9.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	52,001	53,290	328,897	6.17	30
31	Medical Records	2,673	2,788	42,023	15.07	31
32	Other Health C: See attachment	7,643	7,851	63,814	8.13	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	248,988	256,761	$ 2,103,580 *	$ 8.19	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	9,600	9(3)	36
37	Medical Records Consultant	18	540	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	146	7,275	12(3)	45
46	Other(specify)				46
47	Psychiatric Consultant	274	13,702	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	438	$ 31,117		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Jackson (Jan - March)	Administrator	0.00%	$ 9,598
Veronica Hunter	VP Operations	0.00%	36,623
Ronald A. Hunter	Administrative	100.00%	58,679
Gloria Jean Emery (April - Dec)	Administrator	0.00%	30,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,100

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Neil Thompson	Accounting	$ 51,692
Brandon, Schmidt, et. al.	Legal	1,728
Hendrick & Hagen	Legal	1,558
Stratton, Giganti, et. al.	Legal	10,044
Bernard Hoffman & Assoc.	Medicare consultant	3,000
Heller Finance	Financial consultant	2,500
Greg Johnson	Computer Consultation	64
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,586

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,274
Unemployment Compensation Insurance	97,362
FICA Taxes	158,539
Employee Health Insurance	42,432
Employee Meals	74
Illinois Municipal Retirement Fund (IMRF)*	
Employee drug testing	2,067
Employee morale	2,170
Workers' compensation - employee medical expense	28,529
TOTAL (agree to Schedule V, line 22, col.8)	$ 370,447

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
None		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,856
Health Care Worker Background Check	856
(Indicate # of checks performed 73)	
Various dues & subscriptions	824
Less: Public Relations Expense	(225)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Nursing seminars & training	555
Computer training	265
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 820

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4			NONE										
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cardinal Health Care # 0044313 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,500** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,291**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **74** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **None**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.